State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage Under the Affordable Care Act

Section 1305:

Eligibility for Medicaid Affordable Care Coverage Groups

December 2013
March 2014 (T)

Rhode Island Executive Office of Health and Human Services
Access to Medicaid Coverage Under the Affordable Care Act

Rules and Regulations Section 1305:

Eligibility for Medicaid Affordable Care Coverage Groups

TABLE OF CONTENTS

Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1305 of the Medicaid Code of Administrative Rules entitled, "Eligibility for Medicaid Affordable Care Coverage Groups"** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et. seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

1305 Eligibility for Medicaid Affordable Care Coverage Groups

1305.01 Overview

Rhode Island created a new eligibility system to implement the federal Affordable Care Act of 2010. This new system has the capacity to determine whether an individual or family qualifies for affordable coverage paid for by Medicaid, or in whole or in part, by federal tax credits or other subsidies. Toward this end, the system uses a distinct income standard – Modified Adjusted Gross Income or MAGI – to determine eligibility for affordable coverage across populations. Use of the system is being phased in over the course of several years. On January 1, 2014, all new applicants in the Medicaid affordable care coverage (MACC) groups identified in section 1301 of the Medicaid Code of Administrative Rules (MCAR) will be required to apply using the new eligibility system in accordance with the provisions set forth in MCAR section 1303.

1305.02 Scope and Purpose

Income eligibility for MACC groups -- families and parent/caretakers, children and young adults, pregnant women and adults age 19 to 64 – is determined on the basis of the MAGI, as indicated in MCAR section 1307. The purpose of this rule is to provide an overview of the income eligibility thresholds for each MACC group and to establish all other non-financial requirements that MACC group members must meet to be determined eligible for Medicaid affordable coverage. The rule also sets forth the respective roles and responsibilities of applicants for Medicaid and the Executive Office of Health and Human Services (EOHHS) in its capacity as the Medicaid Single State Agency ("Medicaid agency").

1305.03 Definitions

"**Caretaker or caretaker relative**" means any adult living with a Medicaid-eligible dependent child that has assumed primary responsibility for that child inclusive of the categories of caretaker relatives established in MCAR section 0328.10.

"**Dependent child**" means a child under the age of eighteen (18) or under age nineteen (19), if enrolled full-time in school.

"Enrollee" means a Medicaid member or beneficiary is enrolled in a Medicaid managed care plan.

"Hospital Presumptive Eligibility" means Medicaid eligibility granted on a temporary basis to a person who meets certain criteria during a defined period.

"Managed Care Organization (MCO)" means a health plan system that integrates an efficient financing mechanism with quality service delivery and a "medical home" to assure appropriate preventive care and deter unnecessary services.

"Medicaid Affordable Care Coverage (MACC) Group" means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014.

"**Medicaid Code of Administrative Rules (MCAR)"** means the compilation of rules governing the Rhode Island Medicaid Program, promulgated in accordance with the State's Administrative Procedures Act (RIGL §42-35).

"Medicaid member" means a person who has been determined to an eligible Medicaid beneficiary.

"**Modified Adjusted Gross Income or (MAGI)"** means income, adjusted by any amount excluded from gross income under section 911 of the IRS Code, and any interest accrued. Social Security benefits are not included in gross income. The MAGI is the standard for determining income eligibility for all Medicaid affordable care coverage groups (MCAR section 1301).

"Navigator" means a person working for a State-contracted organization that provides certified assisters who have expertise in Medicaid eligibility and enrollment.

"New Applicant" means an individual or family who was not enrolled in and receiving Medicaid coverage on the January 1, 2014, effective date of this rule. The term does not apply to individual and families who were receiving coverage and were disenrolled for any reason; nor does it apply to parents with income between from 133% to 175% of the FPL who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended).

"**Non-citizen**" means anyone who is not a U.S. citizen at the time of application including lawfully present immigrants and persons born in other countries who are present in the U.S. without documentation.

"**Non-MAGI Coverage Group**" means a Medicaid coverage group that is not subject to the modified adjusted gross income eligibility determination. Includes Medicaid for persons who are aged, blind or with disabilities and persons in need of long-term services and supports as well as individuals who qualify for Medicaid based on their eligibility for another publicly funded program, including children in foster care and anyone receiving Supplemental Security Income (SSI) or participating in the Medicare Premium Assistance Program.

"Qualified non-citizen" means a person legally present in the United States on the basis of immigration status who, if otherwise eligible for Medicaid, is prohibited or "barred" under federal law from receiving Medicaid coverage for a period of five (5) years from the date the immigration status was secured from the U.S. Immigration and Naturalization Service (INS). Certain qualified non-citizens are exempt from the ban, as specified in MCAR section 1305.15.

"Rhody Health Partners" means the Medicaid managed care service delivery system for eligible adults without dependent children, ages 19 to 64 (see MCAR section 1310) and adults with disabilities eligible (see MCAR section 0374).

"**RIte Care**" means the Medicaid managed care delivery system for eligible families, pregnant women, children up to age 19, and young adults older than age 19 (see section 1309 of the Medicaid Code of Administrative Rules).

"RIte Share" means the Medicaid premium assistance program for eligible individuals and families who have access to cost-effective commercial health insurance plans coverage.

"Self-Attestation" means the act of a person affirming through an electronic or written signature that the statements the person made when applying for Medicaid eligibility are truthful and correct.

"**Title XIX"** means the section of the U. S. Social Security Act that established the Medicaid program and provides the legal basis for providing services and benefits to certain populations in each MACC group.

"Title XXI" means the section of the U. S. Social Security Act that established the Children's Health Insurance Program (CHIP) and provides the legal basis for providing services and benefits to certain targeted low income children and pregnant women through Medicaid.

"Transitional or Extended Medicaid" means the program that continues Medicaid coverage for up to twelve (12) months for MACC group families covered under Section 1931 when income exceeds the 110% of the FPL threshold.

1305.04 Overview MACC Groups

This rule applies to new applicants who are members of the Medicaid affordable care coverage groups described in MCAR section 1301. All MACC group members are subject to the MAGI standard set forth in MCAR 1307. The chart below provides a brief description of each of the MACC groups and the applicable income eligibility thresholds:

MAC Coverage Groups	Federal Poverty Level (FPL) Income Thresholds
Families and Parents/Caretakers with income up to 133% of the Federal Poverty Level (FPL) – Includes families and parents/caretakers who live with and are responsible for dependent children under the age of 18 or 19 if enrolled in school full-time. It also includes families eligible for time-limited transitional Medicaid.	133%
Pregnant women. Members of this coverage group can be of any age. The pregnant woman and each expected child are counted separately when constructing the household and determining family size. Eligibility extends for the duration of the pregnancy and two months post-partum. The coverage group includes all pregnant women with income up to 253% of the FPL, regardless of whether the legal basis of eligibility is Medicaid or CHIP, including pregnant women who are non-citizen residents of the State. The unborn child's citizenship and residence is the basis for eligibility.	253%
Children and Young Adults. Age is the defining characteristic of members of this MACC group. This coverage group includes: infants under age 1, children from age 1 to age 19 with income up to 261% of the FPL; and qualified and legally present non-citizen infants and children up to the age of 19, who have income up to 261% of the FPL.	261%
Adults 19-64. This is the new Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. The group consists of citizens and qualified non-citizens with income up to 133% of the FPL who meet	133%

MAC Coverage Groups	Federal Poverty Level (FPL) Income Thresholds
the age characteristic and are not otherwise eligible for, or enrolled in, Medicaid under any other state plan or Section 1115 waiver coverage group. Adults found eligible for Social Security benefits are also eligible under this coverage group during the two (2) year waiting period.	

The income levels for MACC groups identified above are eligibility thresholds that do not reflect adjustments made during the MAGI calculation. The FPL levels identified in this rule and other sections of the MCAR applicable to MACC groups should be viewed by consumers accordingly. For more detailed information, see MCAR sections 1301.03 and 1307.

1305.05 Non-MAGI Excluded Medicaid Coverage Groups

Consumers seeking Medicaid coverage who are members of any of the following groups are not subject to MAGI-based determinations on or after January 1, 2014, until notified otherwise by the Medicaid agency:

- Any person for whom the Medicaid agency is not required to make an income determination, such as foster care, adoption assistance, Supplement Security Income beneficiaries.

- Persons seeking eligibility under sections MCAR 0352, 0374, and 0375 who are 65 and older or between the ages of 19 and 64 and seeking eligibility based upon blindness or a disability.

- Anyone applying for eligibility under MCAR section 0378 who is seeking long term services and supports in an institutional or home or community based setting.

- Persons seeking eligibility as "medically needy" due to excess income.

- Anyone eligible for Medicare cost-sharing assistance through the Medicare Premium Payment Program.

- Medicaid beneficiaries determined eligible prior to January 1, 2014 who are still enrolled for coverage on that date are not subject to MAGI-based eligibility redeterminations until 2015. Any reported changes affecting eligibility or the discontinuation of coverage will require reapplication in accordance with section 1303. This excludes parents enrolled in RIte Care with income from 133% to 175% of income who are disenrolled because they are no longer Medicaid eligible under Rhode Island law effective January 1, 2014.

1305.06 Application Process for New Applicants – MACC Groups

Effective January 1, 2014, all new applicants for Medicaid in the MACC groups identified above and in greater detail in MCAR section 1301 must apply using the automated eligibility system established in conjunction with the federal Affordable Care Act. Consumers seeking coverage may apply by accessing the eligibility system web portal through links on the EOHHS (www.eohhs.ri.gov) or Department of Human Services (DHS) (www.dhs.ri.gov) websites or through the HealthSourceRI

(healthsourceri.com), the State's health insurance exchange or marketplace. MCAR section 1303 identifies other channels for applying for coverage through the eligibility system in person and by mail or by telephone through a DHS field office or the Contact Center.

1305.07 MAGI-based Income Eligibility Determination

Income eligibility determinations are based on MACC group income thresholds. The MAGI uses federal tax filings to construct an applicant's household and calculate income, which is then adjusted for family size and compared to the FPL thresholds summarized in section 1305.04 above. The provisions governing MAGI income eligibility determinations for MACC groups are set forth in section 1307.

1305.08 Overview of MACC Group Non-Financial Requirements

All applicants for MACC Group eligibility must meet citizenship and residency requirements. These two requirements apply to all Medicaid applicants. There are also certain cooperation requirements. Adults must typically meet the cooperation requirements, whether applying for themselves or on behalf of a dependent child. Verification of these requirements is an automated process conducted through the federal data hub (see MCAR section 1308) and Rhode Island's own data-based matches. Failure to meet Medicaid non-financial eligibility requirements or provide supporting documentation thereof typically results in the denial or discontinuation of eligibility. Children are typically exempt from sanctions due to non-cooperation. The scope and application of each the non-financial eligibility requirements are set forth in the succeeding provisions of this rule.

1305.09 Age

"Age" is one of the principal factors affecting eligibility for Medicaid and assignment to the appropriate Medicaid service delivery system MACC group.

01. MACC Group Age Limits –The age requirements associated with each of the MACC groups is as follows:

MAC Coverage Groups	Age Requirements
Families and Parents/Caretakers with income up to 133% FPL	• Parents/Caretakers of any age • Dependent child up to age 18 or 19 if enrolled in school full-time
Pregnant Women	• Any age
Children and Young Adults	• Up to age 19
Adults without children	• Ages 19 to 64

Note: Certain children and young adults in non-MAGI coverage groups remain eligible after age 19. Young adults eligible on the basis of participating in the Non-IV-E Adoption Subsidy Program or Supplemental Security Income (SSI) are covered up to age 21; former foster children remain eligible up to age 26.

02. Verification – An applicant's self-attestation of age and identity is accepted at the time of application. Post-eligibility electronic verification of date of birth is conducted through the U.S. Social Security Administration (SSA) and/or the RI Department of Health, Division of

Vital Statistics. This information is used to determine capitation rates for enrollees in Medicaid managed care plans; these rates vary by age. If electronic verification is unsuccessful, submission of paper documentation may be required for these purposes. See MCAR section 1308.10 for satisfactory forms of documentation.

1305.10 Social Security Number

Each individual (including children) applying for Medicaid must have a Social Security Number (SSN) as a condition of eligibility for the program.

01. Condition of Eligibility – Applicants must be notified prior to or while completing the application that furnishing an SSN is a condition of eligibility. Only members of a household who are applying for Medicaid coverage are required to provide a SSN. A SSN of a non-applicant may be requested to electronically verify income. However, unwillingness on the part of a non-applicant to provide a SSN upon request cannot be used as a basis for denying eligibility to an applicant who has provided a SSN. If unavailable, other proof of income must be accepted.

02. Limits on Use – Applicants must also be informed that a SSN will be utilized only in the administration of the Medicaid program, including for use in verifying age and income eligibility.

03. Verification – A SSN is verified through an electronic data-match with the SSA. Applicants must provide documentation of SSN if the data match fails. Acceptable forms of documentation are identified in MCAR section 1308.10.

Note: The provisions governing SSNs for newborns, sometimes referred to as enumeration, are located in section 1305.14.

1305.11 State Residency

The Medicaid program exists primarily to meet the needs of residents of Rhode Island. Therefore, as a factor of eligibility, anyone who is applying for eligibility must be a resident of the State. Any person living in the State voluntarily, who intends to reside in Rhode Island for any reason is a resident of the State. Under federal regulations implementing the Affordable Care Act, a person does not need a fixed address in the State to be considered a Rhode Island resident. Therefore, homelessness is not a bar to eligibility.

01. For individuals over age 21, or under 21 and capable of expressing intent as emancipated or married — If the applicant is not living in an institution, the state of residence is the state where the applicant is living voluntarily with the intention to reside; or entered voluntarily with a job commitment or seeking employment, whether or not currently employed.

02. For individuals under age 21 who are not emancipated or married – If the applicant is not living in an institution, the state of residence is the state where the child/young adult resides or the state of the parent/care-taker with whom the child lives. The residence of a pregnant women's unborn child is, under the terms of this provision, the state in which the pregnant women resides. A non-citizen pregnant woman who lives in Rhode Island is considered to be a resident, irrespective of

whether the woman's immigration status indicates she is in the country permanently or for a limited time (i.e., in the United States on a temporary visa of any kind).

03. For individuals living in institutions – Most Medicaid applicants living in institutional settings are not included in the MACC groups. For applicants in these non-MAGI coverage groups, the applicable provisions are set forth in section 0304.10.05.25.

04. Disputes – If there is a dispute over residency for determining Medicaid eligibility, the applicant is a resident of the state in which the applicant is physically located. The MAGI standard of the state where the applicant is physically located applies when determining eligibility.

05. Verification – Self-attestation of the intent to remain in the State is accepted. Evidence that an applicant is receiving public benefits in another state may result in a denial of eligibility if paper documentation of residency is not provided. Further information on residency is set forth in MCAR section 1308.10.

1305.12 Citizenship and Immigration Status

The citizenship requirements for Medicaid eligibility for individuals and families in MACC groups vary depending on the basis of eligibility. All applicants must provide information about citizenship, whether U.S. citizens or lawfully present non-citizens.

01. Categories of Non-citizens Qualified v. non-qualified non-citizens – Under federal law, non-citizens are categorized into two groups – qualified and non-qualified non-citizens.

    (01) Qualified non-citizens. The qualified non-citizens category includes persons who are citizens of other nations who are lawfully present in the United States. Qualified non-citizens are barred from Medicaid for a period of five (5) years under federal law. Certain exemptions from the bar apply:

    - Qualified non-citizen children up to age 19 who are lawfully present in the United States but were born in another nation are eligible for Medicaid as members of the MACC group for children and young adults. The State elected to offer children in this subcategory of qualified non-citizens eligibility during the five (5) year bar under an option in Title XXI, the Children's Health Insurance Program (CHIP). Qualified non-citizen pregnant women are also eligible for Medicaid in the MACC group, again under an option in CHIP.

    - There are several other subcategories of non-citizens who are exempt from the five (5) year bar as specified in MCAR section 0304.05.15.

    - All non-exempt qualified non-citizens are eligible to obtain coverage through state and federal health insurance marketplaces, such as HealthSourceRI.com in Rhode Island, and may be qualified for certain tax credits.

    (02) Non-qualified non-citizens. The non-qualified category of non-citizens includes citizens of other nations who are not considered to be immigrants under current federal law,

including those in the United States on temporary or time-limited visa (such as visitors and students) and those who are present in the country without proper documentation (includes people with no or expired status).

- Non-qualified non-citizens are not eligible for Medicaid, except in emergency situations (see MCAR section 0304). Non-emergency services may be obtained through Federally Qualified Community Health Centers. See Rhode Island Community Health Association at www.richa.org.

- Non-qualified non-citizen pregnant women in the applicable MACC group are eligible for Medicaid coverage. The pregnant woman's eligibility is tied to the eligibility of the baby she is carrying. For the purposes of MACC group eligibility, the baby *in utero* is deemed to be a United States citizen and Rhode Island resident and remains so as a newborn as long the birth occurs in Rhode Island.

More detailed information on the citizenship and immigration status is located in MCAR section 0304.05

02. Verification of status—Any members of a household who are applying for Medicaid coverage must provide their immigration and citizenship status. Non-applicants are exempt from the requirement. Any information provided by an applicant or electronically must be used only for verifying state. Under the ACA, citizenship and immigration status are verified:

(01) Electronically. The Medicaid agency must use electronic verification through the federal hub (see MCAR section 1308.08.04 d) to the full extent feasible through:

- Social Security Administration (SSA) or RI Department of Health, Division of Vital Statistics for citizens.

- U.S. Citizenship and Immigration Services (USCIS) for non–U.S. citizens via the Systematic Alien Verification for Entitlements (SAVE) database.

(02) Non-electronic. If unable to verify immigration status electronically, enrollees have an opportunity to provide other documents or to fix the records.

(03) Self-Attestation. An applicant's attestation is accepted without electronic verification providing appropriate paper documentation is provided to the Medicaid agency within ninety (90) days of the eligibility determination. Failure to provide the required documentation within that period results in a termination of Medicaid and the initiation of the Medicaid recoupment process.

1305.13 Relationship

To facilitate implementation of the ACA and the transition to the MAGI standard in the most efficient way possible, many of the eligibility requirements separating Medicaid eligible populations into discrete coverage groups were eliminated outright or consolidated and/or revamped. The non-financial eligibility criteria related to relationship for parents and caretaker relatives and dependent children

established in Title XIX that incorporated Aid to Families with Dependent Children (AFDC) standards were among the requirements changed as part of this process. Effective on January 1, 2014, the State will evaluate the eligibility of members of the MACC group for families and parent/caretakers using the more inclusive definitions that follow:

01. Caretaker Relative – For the purposes of MACC group eligibility, parent/caretaker is any adult living with a Medicaid-eligible dependent child who has assumed primary responsibility for that child. This definition includes, but is not limited to:

    - Father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew or niece;

    - The spouse of such parent or relative, even after the marriage is terminated by death or divorce; or

    - Another relative of the child based on blood, adoption or marriage; domestic partner of parent or other caretaker relative.

If the parents are in the household, it is presumed that other members in the household are not assuming primary responsibility for the child's care.

02. Dependent child – For the purposes of determining eligibility the members of the MACC group for families and parents/caretakers, a dependent child is a child under the age of eighteen (18) or under age nineteen (19) if enrolled full-time in school. The provisions related to deprivation of child set forth in section 0328.15 are no longer applicable and have been repealed.

03. Verification – Attestation on the application is accepted as verification of relationship.

1305.14 Newborn Eligibility

Babies born to Medicaid members who are pregnant are deemed eligible from the date of birth.

01. Newborn deeming – The eligibility of a child born to a woman who is a Medicaid enrollee on the date of the child's birth is based on the following:

    (01) Date of eligibility. The newborn is deemed eligible for Medicaid on the date of birth.

    (02) Continuing eligibility. Once the deem eligible as a newborn, the infant remains eligible for one (1) year providing that the infant resides continuously in the mother's household and the mother remains eligible for Medicaid or would have remained eligible if she were still pregnant.

    (03) Discontinuation of eligibility. If at any time it is determined that the mother would not remain eligible if she were still pregnant, or that the infant is not residing in the mother's household, the infant loses deemed eligibility. In such instances, the Medicaid agency must determine whether the infant is eligible for Medicaid on any other basis.

02. Enumeration – A Medicaid enrollee who is the parent of a newborn must obtain a SSN for a newborn. Failure to enumerate the child results in a sanction against the mother, not the child. The child will remain eligible even if lacking an SSN because of mother's failure to cooperate. The sanction against the mother is loss of her eligibility for failure to cooperate. This sanction will be removed once the mother meets the enumeration requirements.

03. Verification – The birth may be reported by the mother, or another family member or friend, the mother's Medicaid managed care plan, or the hospital in which the child was born. See section 0342.40.10 for information pertaining to the hospital record of birth.

1305.15 Hospital Presumptive Eligibility

Under the implementing regulations for the federal Affordable Care Act at 42 Code of Federal Regulations (CFR) 435.1110, states must offer Medicaid coverage to individuals who are not already Medicaid members for a limited period. This form of "presumptive eligibility" is only available in certain circumstances when a qualified hospital determines, on the basis of preliminary information, that an individual has the characteristics for Medicaid eligibility. Such individuals are "presumed eligible" for Medicaid until the end of the following month or the date full eligibility is determined, whichever comes first.

01. Implementation – Effective January 1, 2014, the State will be making presumptive eligibility available to individuals who have been determined by a qualified hospital to meet the characteristics of one of the MACC groups identified in MCAR section 1301 eligible for Title XIX coverage. Persons eligible under CHIP are excluded. A qualified hospital is, for these purposes, any licensed hospital in the State participating in the Medicaid program that makes a written request to conduct PE determinations, participates in training and certification and remains in good standing with State protocols.

02. Governing Provisions – The State will proceed to rule-making prior to the January 1, 2014 implementation date adopting new rules or amendments setting forth the provisions governing the determinations of hospital presumptive eligibility. The State will establish at that time how the Medicaid agency will use the flexibility afforded under federal regulations to: set forth the criteria that a qualified hospital must use when making a determination of presumptive eligibility; and establish application timelines and procedures for the individuals who qualify for Medicaid coverage during the presumptive eligibility period. The Medicaid agency will also establish which populations may qualify and on what basis. The Medicaid agency is working closely with qualified hospitals in the State to develop these provisions to assure both ease of administration and access and efficient use of limited resources.

1305.16 Special Eligibility Considerations

The full implications of implementation of the ACA for certain Medicaid coverage groups have not been determined fully as of the effective date of this rule - January 1, 2014. Until further notice by the Medicaid agency, eligibility for these coverage groups is as indicated below.

01. Section 1931 Transitional Medicaid – As indicated in MCAR section 1303, families eligible for Medicaid under section 1931 of Title XIX, the federal Medicaid law, may be eligible for an extension of Medicaid for up to twelve (12) months when their income exceeds the income

thresholds for their coverage group. Until further notice, eligibility for transitional/extended Medicaid will be conducted in accordance with the provisions set forth in MCAR section 0342.50.

02. Refugee Medicaid - Until further notice, eligibility for Medicaid refugees will be conducted in accordance with the provisions of MCAR section 0342.90.

1305.17 Cooperation Requirements

All applicants are required to provide truthful information. In addition, applicants must cooperate with the following requirements as a condition of obtaining or retaining (post-eligibility) eligibility in terms specified:

01. Third Party Liability (TPL) – Third Party Liability refers to any individual, entity (e.g., insurance company) or program (e.g., Medicare) that may be liable for all or part of a Medicaid applicant's coverage. Under Section 1902(a)(25) of the Social Security Act, the Medicaid agency is required to take all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of the Medicaid member once determined eligible. Applicant must furnish information about all sources of TPL. The health plan and the State are responsible for identifying and pursuing TPL for individuals covered by employer-sponsored health insurance plans through the RIte Share program. Failure to cooperate with the TPL requirement or to enroll in a RIte Share plan as required in section 1312 results in the ineligibility of the parent.

02. Referral to Office of Child Support Services (OCSS) – All applicants reporting an absent parent are referred to the Office of Child Support Services within the Department of Human Services, once they have been determined eligible for Medicaid and received appropriate notice. Compliance with the OCSS requirement is a condition of retaining eligibility. As a condition of eligibility, an applicant who can legally assign rights for a dependent child born out of wedlock is required to do so and cooperate in establishing the paternity of that child for the purposes of obtaining medical care support and medical care payments for both the applicant and the child. Failure to cooperate in assigning rights results in a determination of ineligibility for the parent, unless a good cause exemption has been granted by the Medicaid agency. In instances when domestic violence may be the basis for an exemption to the cooperation requirement, referral to the Family Violence Option Project may be made to assist the parent seeking an exemption.

03. RIte Share Premium Assistance Program – Individuals and families determined to have access to cost-effective employer-sponsored health insurance (ESI) are required to enroll in the ESI plan if so directed by the Medicaid agency. Beginning on January 1, 2014, Members of the MACC groups with access to ESI who are eligible for Medicaid will be permitted to enroll in a Medicaid managed care plan, as appropriate. The Medicaid agency will conduct a post-enrollment review of those members with access to ESI to determine whether participation in RIte Share is required. The provisions governing the RIte Share program are located in section 1312.

04. Duty to Report – All Medicaid applicants and beneficiaries have a duty to report changes in income, family size, address, and access to ESI within ten (10) days of the date the change takes effect. Failure to make timely reports may result in the denial or discontinuation of Medicaid eligibility.

1305.18 Good Cause for Non-Cooperation

A Medicaid applicant or member must have the opportunity to claim good cause for refusing to cooperate. Good cause may be claimed by contacting a DHS or EOHHS agency representative. To claim good cause, a person must state the basis of the claim in writing and present corroborative evidence within twenty (20) days of the claim; provide sufficient information to enable the investigation of the existence of the circumstance that is alleged as the cause for non-cooperation; or, provide sworn statements from other individuals supporting the claim.

A determination of good cause is based on the evidence establishing or supporting the claim and/or an investigation by Medicaid agency staff of the circumstances used as justification for the claim of good cause for non-cooperation.

The determination as to whether good cause exists must be made within thirty (30) days of the date the claim was made unless the agency needs additional time because the information required to verify the claim cannot be obtained within the time standard. The person making the claim must be notified accordingly.

Upon making a final determination, notice must be sent to person making the claim. The notice must include the right to appeal through the EOHHS Administrative Fair Hearing Process specified in section 0110.

1305.19 Information
REV: March 2014

For Further Information or to Obtain Assistance

01. Applications for affordable coverage are available online on the following websites:
    - www.eohhs.ri.gov
    - www.dhs.ri.gov
    - www.HealthSourceRI.com

02. Applicants may also apply in person at one of the Department of Human Services offices or by U.S. Mail. Request an application by calling 1-855-609-3304 and TTY 1-888-657-3173.

03. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

1305.20 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.